

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>07-06</b>	2. STATE <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>April 1, 2007</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>§1902 (a)(30) of the Social Security Act 42 CFR Part 447.204</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>4/1/07-9/30/07</b> <b>(\$13,432,500)</b> b. FFY <b>10/1/07-9/30/08</b> <b>(\$26,865,000)</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B: Pages 1(b), 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) &amp; 7(a)(i)      ** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-B: Pages 1(b), 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) &amp; 7(a)(i)</b>	
10. SUBJECT OF AMENDMENT: <b>2007 Cost Containment Extensions—Non Institutional FMAP = 50% (based on effective date of 4/1/07)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: /		16. RETURN TO: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Donna Frescatore</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>AUG 20 2010 (Originally Submitted June 28, 2007)</b>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: <b>OCT 18 2010</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APR 01 2007</b>		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: <b>Sue Kelly</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS:  <b>Originally submitted pages Attachment 4.19-B-Page 1(b), 1(c)(ii), 1(d), 1(e), 2, 2(a)(i), 2(b), 2(b)(i), 2(c), 4, 4(a), 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v) and 7(a)(i) have been replaced by revised pages submitted via State e-mail of August 20, 2010.</b>			